

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:

County HowardCity or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Michigan County LivingstonCity or town Lansing
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 N. Clemens Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Peter Coopes

3. (b) Social Security Number

380-05-4337

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Caroline Coopes

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 24, 18948. AGE: Years 54 Months 1 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Lansing, Mich.
(Town, county, and state)10. Usual occupation Tool maker11. Industry or business Auto12. Name John Coopes13. Birthplace Mich14. Maiden name Martha M. Court15. Birthplace Mich16. Informant Mrs. Caroline CoopesAddress 118 N. Clemens Ave Lansing Mich17. Burial Date thereof 9-1-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt HopeLocation Lansing Mich18. Funeral director F.C. HigginbothamAddress Elliot City Md19. Aug 28 48 (Date rec'd by registrar) Miss Bidwell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 48 at 11 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 48 to Aug 27 48 and that I last saw him alive on at no times

Immediate cause of death

Coronary Occlusion

DURATION

10 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

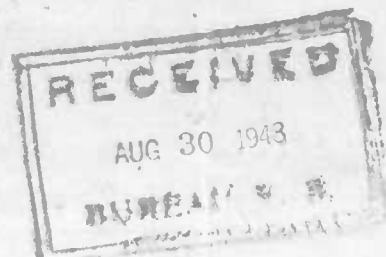
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Alpha W. Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Elliot City Md Date signed 8-27-48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 190

1. PLACE OF DEATH:

County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:
6601 Old Wash Blvd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6601 Old Wash Blvd
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Vinona Theresa Doyle

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Thomas J Doyle

7. Birth date of

deceased (mo., day, yr.)

June 23 - 1900B.(c) If alive, give age 30 years

8. AGE:

Years

Months

Days

If less than one day

48124hrs.min.

9. Birthplace

Frederick md
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Housewife

12. Name

Jessie H. Crum

13. Birthplace

Frederick md

14. Maiden name

Wilhelmina A. Ralke

15. Birthplace

Frederick md

16. Informant

Thomas J Doyle

Address

6601 Old Wash Blvd Elkridge

17.

(Burial, cremation, or removal. Which?)

Date thereof August 20, 1948
(month) (day) (year)

Cemetery or crematory

BALTIMORE NATIONAL

Location

Baltimore Md.

18. Funeral director

Thomas W. SINGLETON

Address

Glen Burnie, Md.

19.

Aug 19
(Date read by registrar)

19

48

(min)

1hrs00min00

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 16 1948, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1948, to Aug 16 1948and that I last saw him alive on Aug 16 1948

Immediate cause of death

apoplexy

DURATION

1 day

Due to

myocardial

DURATION

2 mo

Due to

arteriosclerosis

Other conditions

hypertensionatherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B.B. Brumby

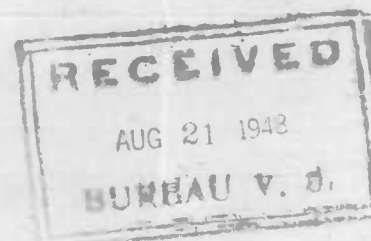
M. D. or other

Address

Elkridge Md

Date signed

Aug 19 48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Howard
 City or town near Laurel R.D.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

Nancy V. Foster

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) JAN. 6, 1874 6. (c) If alive, give age — years8. AGE: Years 74 Months 7 Days 17 If less than one day — hrs. — min.9. Birthplace Paleyville, Virginia
(Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Jacob Ribler13. Birthplace Paleyville, Va14. Maiden name Amanda Richard15. Birthplace Paleyville Va16. Informant Mrs. Amanda RedmilesAddress North Laurel Md.17. burial Date thereof Aug 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount OliveLocation Hayfield Virginia18. Funeral director OmbsAddress Winchester Virginia8/24/48 Frank Shively

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Va County —
 City or town Hayfield
 (If outside city or town limits, write RURAL and give nearest town)

Street No. —
 (If rural, give LOCATION) ✓

2. (a) If veteran, name war —

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 23 19 48, at 3 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 19 48, to Aug 23 19 48
 and that I last saw him alive on Aug 23 19 48.

Immediate cause of death Indocarditis, Myocarditis
 DURATION 4-

Due to Myocarditis - IndocarditisDue to —Other conditions —

(Include pregnancy within 3 months of death)

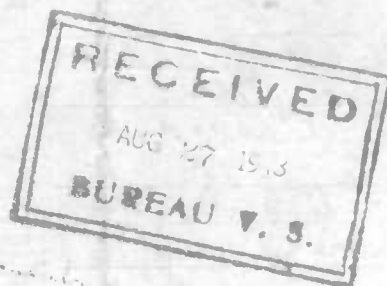
Major findings of operations —Autopsy results — Date of op. —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — injured at work? —23. SIGNATURE Dr. B. J. J. J.Address Laurel Md M. D. or other 8/23/48Date signed 8/23/48

1948-8-23
74-7-17
1894-1-06



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08441

195

1. PLACE OF DEATH:

County... HowardCity or town... Waterloo
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HowardCity or town... Waterloo
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William Albert Shipley

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?) Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 8/18/48

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. of other

Address

Date signed

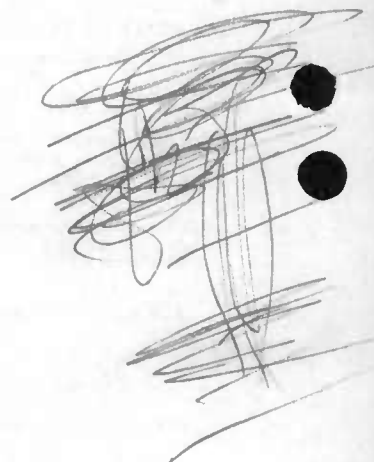
DURATION

1 yr 4

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 138 08442 171

1. PLACE-OF DEATH:

County Howard CountyCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Toogood

4. Sex

Male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Lucy Toogood

7. Birth date of

deceased (mo., day, yr.) October 7, 1885

8. AGE:

Years 62 Months 9 Days 27 If less than one day

9. Birthplace

Howard Co., Ind.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name Charles Toogood13. Birthplace Howard County, Ind.

MOTHER

14. Maiden name Sarah15. Birthplace Howard County, Ind.16. Informant Lucy ToogoodAddress 2102 Church Ave.17. Burial Date thereof Aug. 6, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lanier's HillLocation Wash. Blvd.18. Funeral director Mrs. Katie R. WilliamsAddress 322 N. Schenck St.19. Aug 5 1948 C. W. Hedens
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Indy County Howard Co.City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 2102 Church Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1948 at 5:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 1948 to August 3, 1948and that I last saw him alive on at no time 1948

Immediate cause of death

Pulmonary tuberculosisDURATION 1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alpha M. Herbert, M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Elkridge, Ind. Date signed 8-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
 City or town Shilford
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Shilford
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Vaughn Washington
 4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Widow

3. (b) Social Security Number

None

6.(b) Name of husband or wife

B.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name unknown13. Birthplace "14. Maiden name "15. Birthplace "

18. Informant Joseph Ewery
 Address Shilford Md

17. Burial Date thereof 8-26-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St StephensLocation Elkridge Md.18. Funeral director W.D. McWhorterAddress Ellicott City Md

19. Aug 26 19 48 John B. Longman
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 19 48 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 19 48 to Aug 19 19 48
 and that I last saw deceased alive on at no time 19 48

Immediate cause of death

Coronary Occlusion
 Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Alpha N. Herbert M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
 Address Ellicott City Md Date signed 8-19-48

